Kentucky Department for Public Health
Division of Epidemiology and Health Planning
275 East Main St., Mailstop HS1E-C
Frankfort, KY 40621-0001

Hepatitis B Infection in Pregnant Women or Child

Mail Form to Local Health Department

DEMOGRAPHIC DATA

Patient's Last Name	First	M.I.	Date of Birth / /	Age	Gender ☐ M ☐ F ☐ Unk
Address	City	State	Zip		County of Residence
Phone Number	Patient ID Number	Ethnic Origin ☐ His. ☐ Non-His.	Race ☐ W ☐ B ☐ A/PI ☐ Am.Ind ☐ Other		

Date of Onset / /	Describe Clinical Symptoms:	
Jaundice ☐ yes ☐ no		
Is patient pregnant? ☐ Yes ☐ No	Expected Date of Delivery / /	Name of hospital for delivery
Physician Provider:	Address:	Phone:

LABORATORY INFORMATION

Hepatitis Markers	Results	Date of Test	Name of Laboratory
HBsAg	☐ Pos ☐ Neg	/ /	
IgM anti-HBc	☐ Pos ☐ Neg	/ /	
IgM anti-HAV	☐ Pos ☐ Neg	/ /	
Anti-HCV	☐ Pos ☐ Neg	/ /	

Serum Aminotransferase Levels

Patient	Reference:	Date of Test	Name of Laboratory
AST (SGOT) U/L	U/L	/ /	
ALT (SGPT) U/L	U/L	/ /	

Person or Agency Completing form: Name: Agency:	**Return form to LHD or to the KDPH at the above address.**
Address:	
Phone: Date of Report: / /	